South Carolina Department of Disabilities and Special Needs

Provider Pre-Enrollment Information for Participation in the Pervasive Developmental Disorder Waiver/State Funded Program

Name: _____

Address: _____

_____

Telephone: _____

E-mail: _____

Provider Type/ Education (check one):

☐ Bachelor's Degree in _____ (Attach copy of diploma or transcript)

☐ Master's Degree in _____ (Attach copy of diploma or transcript)

☐ Doctorate Degree in _____ (Attach copy of diploma or transcript)

☐ Board Certified Associate Behavior Analyst # _____ (Attach copy of current certification)

☐ Board Certified Behavior Analyst # _____ (Attach copy of current certification)

Provider Qualifications / Experience

☐ 1 year experience as an independent practitioner and/or has supervised a clinician with less experience.

☐ 2 years experience as an independent practitioner and/or has supervised a clinician with less experience.

☐ 3+ years experience as an independent practitioner and/or has supervised a clinician with less experience.

I certify the information given above concerning my credentials and work experience is accurate.

_____ _____

Enrollee's Signature Date

The information noted above and information submitted has been reviewed and verified.

_____ _____

DDSN – Autism Division Date